Time-Based Services

How many of you have been under the impression that if time is used as the controlling factor in E/M code assignment, that the "key components" (history, exam, and mdm) are not necessary to consider?

Most of us were, but this is not technically correct according to CMS.

CMS Guidance states (found in the .pdf document download on page 4, section c):

"In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim."

In this statement, CMS is telling us that the MDM must be considered in conjunction with the time spent. Other CMS, AMA, and miscellaneous resources we have reviewed state that the provider must document the total time and describe the counseling/coordination of care consisted of to support the medical necessity. However, this statement is different as it advises that the time AND the MDM must support the same level of service. After reading this statement you may be concerned that you have been scoring time based documentation incorrectly. But don't overreact- let's break this down.

The time associated with the levels of service and the associated MDM are as follows:

LOS	Total Time	MDM for the LOS
99201	*10*	*SF*
99202	*20*	*SF*
99203	*30*	*L*
99204	*40*	*M*
99205	*60*	*H*
99211	*N/A*	*N/A*
99212	*10*	*SF*
99213	15	L
99214	25	M

99215	40	H

When we compare the time and MDM this way, you can see that while we must still score the MDM, these two elements actually drive each other (i.e. a greater level of MDM generally requires more time spent).

Let's evaluate an example:

I spent 40 minutes in follow-up with this 42 year old patient for her Jersey finger (look it up, it's not what you would think) reviewing the x-ray findings, and evaluating an appropriate plan of care due to the lack of improvement from her previous encounter. We discussed further conservative management, physical therapy trials, and surgical intervention. She prefers to proceed with surgical intervention. No pre-operative clearance required as she has no known co-morbidities.

In this example, while the time documented could support a 99215 by itself, major surgery on a patient with no known risk factors is only a moderate level of MDM and therefore the 99214 would be the appropriate level of service if we apply the CMS rules noted above. Before having concerns that you may have been incorrectly scoring this, think about it this way: wouldn't you have stopped and scratched your head and wondered why 40 minutes was needed for a younger patient with no co-morbidities? The point is, while you may not have scored time-based documentation in this exact manner, your findings more than likely challenged such scenarios that seem "off".

The Good News: The rules that define medical necessity for any service are vague, but this CMS guidance gives us a measuring stick for time based services. As non-clinicians who don't see patients, we have a tough time trying to analyze the medical complexity of billed services, but it should be easier with this clearer guidance for time based services.

This Week's Tip Provided by:

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